

RESIDENTIAL TREATMENT COST REPORT -		2006	SCHEDULE B
Tax Id #: _____			
Facility Name: _____			
Audit Year: _____			
<b>REVENUE:</b>			
<b>1. MEDICAID</b>			
a. HRI-R			
b. CAP-MR			
c. Other Medicaid			
<b>2. TOTAL MEDICAID</b>		\$	-
<b>3. OTHER FEDERAL FUNDS-LIST</b>			
a. IV-E Funds			
b. IV-B Funds			
c. Federal Grants			
d. USDA School Food Service			
e. All Other Federal Funds			
<b>4. TOTAL OTHER FEDERAL FUNDS</b>		\$	-
<b>5. STATE FUNDS</b>			
a. State Funds (Old Grant-in-Aide)			
b. JJDP Funds			
c. Non-Medicaid covered treatment (including At Risk)			
d. State Training Funds			
e. Non IV-E Foster Care Funds (SFHF)			
f. All Other State Funds			
<b>6. TOTAL STATE FUNDS</b>		\$	-
<b>7. COUNTY FUNDS</b>			
<b>8. INVESTMENT INCOME</b>			
<b>9. PRIVATE CONTRIBUTIONS</b>			
<b>10. OTHER</b>			
<b>11. TOTAL REVENUE (Total of Lines 2,4,6,7,8,9,10)</b>		\$	-
<b>12. LESS: TOTAL EXPENSES</b>			
<b>13. NET PROFIT (LOSS)</b>		\$	-